3 Hospice Service Guidelines Contents

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by hospice facilities as deemed appropriate by IDHW. It addresses the following:

- Medicare election
- Required prior authorization
- Election period
- Physician certification
- Hospice election notification
- Physician services
- Reporting requirements
- Electronic and paper claim billing
- Claims payment

Note: Hospice services are covered for **Enhanced Plan** participants.

3.1.2 Client Eligibility

To be eligible for hospice services, a participant must be enrolled in the Medicaid Enhanced Plan and must have a physician-certified prognosis that the participant's life expectancy is six months or less. The participant must also have signed a notice of election for hospice care.

If the participant is enrolled in Healthy Connections, a referral is required from the participant's primary care physician (PCP).

Note: Hospice services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.1.3 Medicare Providers

All hospice agencies must apply for and receive a Medicare provider number before applying to the Idaho Medicaid program for a provider number. A provider's enrollment in the Idaho Medicaid program is separate from its Medicare application.

3.1.4 Advance Directives

When accepting a participant in the Hospice Program, the hospice provider must:

- explain to the participant and the participant's family or caregiver that all services (doctor visits, pharmacy, etc.) will be coordinated with the hospice program, and,
- explain to the participant his/her right to make decisions regarding his/her medical care, including the right to accept or refuse treatment, and
- inform the participant of his/her right to formulate advance directives, such as a living will or durable power of attorney for health care, at the time the participant initially receives hospice care.

3.1.5 Hospice Clients Residing in Nursing Homes or ICF/MR Facilities

Client Liability:

Medicaid participants residing in a nursing facility, who have elected the Medicare or Medicaid hospice benefit, must contribute toward the cost of their hospice care. The amount of each participant's liability (the contribution toward the cost of care) will be determined under the same rules that are currently applied to all other Medicaid nursing facility residents. Medicaid hospice participants will be notified of the amount of their participant liability.

Agreements between hospice agencies and nursing facilities:

A written agreement should be developed by the hospice agency that explains the hospice provider's professional management responsibilities for the individual's hospice care and the facility's agreement to provide room and board to the individual. Hospice agencies will receive 95% of the nursing home daily rate for the nursing facility providing room and board to the hospice client. The hospice agency is then responsible to reimburse the facility for the room and board payment. The participant liability amount should be indicated on the hospice claim form when billing for the nursing home room and board.

3.1.6 Payment

3.1.6.1 Healthy Connections

Check eligibility to see if the participant is enrolled in Healthy Connections, Idaho's Primary Care Case Management (PCCM) model of managed care. If a participant is enrolled, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services. Refer to Section 1.5 in the General Information section of the provider handbook for the Healthy Connections guidelines.

3.1.6.2 Customary Fees

All hospice providers are paid through the use of five predetermined rates for rural or urban providers. Hospice-based physician employee services are billed by the hospice provider on the UB-92 claim form using revenue code 657 and the appropriate CPT procedure codes. Physicians not employed by the hospice must bill independently for their services.

3.1.6.3 Covered Services

All services related to the terminal illness are included in the prospective rates paid. The following services are included in the reimbursement rate:

- Nursing care
- Physician services
- Medical social services
- Counseling services
- Durable medical equipment
- Supplies
- Self-help and personal-comfort items

- Home health and homemaker services
- Physical, occupational, speech, and language therapy
- Medication that is used primarily for the relief of pain and symptom control related to the terminal illness

3.1.6.4 Restrictions

The hospice provider is responsible for providing up to 45 minutes daily of personal care services that are related to the terminal illness. Payment for this service is included in the hospice care daily rate.

Medicaid Personal Care Services may be authorized to provide routine personal care services that are not directly related to the individual's terminal illness. Medicaid PCS services may **not** be substituted for the primary care described above that is required by the hospice provider.

The hospice provider is responsible for services and items related to the terminal illness that another provider renders. Services and supplies not related to the terminal illness for pre-existing conditions are to be billed by the provider rendering the service, not under the hospice provider number.

Example:
Reimbursement for treatment for the alleviation of cancer symptoms is included in the prospective rates paid to a hospice provider. Conversely, if the participant has a pre-existing chronic disease i.e. diabetes, the cost for the diabetic services is reimbursed separate from the hospice services.

3.1.7 Authorization

An authorization is required for any client electing Hospice services. When the client has another insurance as the primary payer, the provider is still required to obtain prior authorization (PA) from the DHW Bureau of Medical Care. The Centers for Medicare and Medicaid Service (CMS) require a hospice agency to notify Medicaid when an individual, who is a Medicare beneficiary, elects or revokes the hospice benefit.

The requesting hospice provider should submit the following documentation to DHW within five (5) working days:

FORM AVAILABLE: The Hospice Intake Form is included in the Forms Appendix of this handbook. Copies can be made as needed by the provider.

- The completed DHW Hospice Intake Form
- The hospice election form signed by the patient or legal representative.
- The attending physician's history and physical.
- The hospice agency's completed Plan of Care, signed by the physician.
- The physician's signed certification stating the individual's medical prognosis for life expectancy is 6 (six) months or less.

The hospice plan of care and the physician's certification is to be signed by the physician within two (2) calendar days of the election of the hospice benefit.

If the client is enrolled in Healthy Connections (HC), Idaho's Primary Care Case Management (PCCM) model of managed care, a HC referral number is required from the participant's primary care physician (PCP).

All claims, both paper and electronic, must have the HC referral number listed on the claim.

3.1.8 Third Party Recovery

See Section 2, Third Party Recovery, regarding DHW policy on billing all other third party resources before submitting claims to Medicaid.

3.2 Hospice Service Policy

3.2.1 Overview

The hospice program is designed to keep the client comfortable, free of pain, and in the least restrictive environment possible while providing services that are reasonable and necessary for the management of a terminal illness and related conditions.

This is strictly an elective program — a client may elect or revoke hospice services at any time during the benefit period. The hospice provider may not coerce or prevent a client's termination of election. The client must acknowledge the waiver of other Medicaid benefits and the purpose of hospice care, in writing, in order to receive hospice care.

Note: Hospice services are covered for **Enhanced Plan** participants.

3.2.1.1 Medicare Primary

If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked simultaneously under both programs.

3.2.2 Election Period

An election period, as identified in the *Rules Governing the Medical Assistance Program*, IDAPA 16.03.09.104.01.f, is any calendar month, or portion thereof, that hospice is elected. There are eight election periods allowed within the hospice benefit period. Each election counts as a calendar month within the benefit period. They are deemed to run consecutively unless revocation of an election has been made by the client. An election period consists of any month or portion of a month a client elects to receive hospice care.

Clients who have used their eighth month period and wish to extend their hospice election period may do so by **not** revoking their hospice election after the eighth month **and** requesting an extension from the DHW Bureau of Care Management. No extension is available if the client has revoked their hospice election in the last month.

3.2.3 Physician Certification

The hospice must obtain a physician certification statement, reflecting a prognosis of life expectancy of six (6) months or less, no later than two (2) calendar days after the client chooses hospice care. A copy must be sent to DHW Bureau of Medical Care.

3.2.4 Hospice Election Notification

When a client elects hospice services, the hospice provider will notify DHW within five (5) working days by faxing the required information on the intake form. This form is included in the *Forms Appendix* of this handbook.

FAX the Hospice Election Notification:

Attn: Hospice
(208) 332-7280

3.2.5 Hospice Revocation

When a patient revokes services or expires, he/she must file a signed statement with the hospice. The hospice agency must notify the DHW Bureau of Medical Care within five (5) working days by faxing a copy of the original intake form with the revocation or death date inserted.

3.2.6 Physician Services

The hospice agency must notify DHW's Bureau of Medical Care of any changes of physicians who are employees, contractors, or volunteers of the hospice agency.

In addition, when the hospice agency submits the information requesting the hospice benefit for an individual, the information should identify whether the physician is an employee, contractor, or volunteer of the hospice agency.

Physicians who render hospice services who are not employees, contractors, or volunteers of the hospice agency, must bill Medicaid directly. The claim form should indicate that they have no affiliation with the hospice agency.

3.2.7 Reporting Requirements

Hospice agencies must report to the DHW Bureau of Medical Care any change in physician affiliation with the hospice agency.

Additionally, hospice agencies must report to the DHW Bureau of Medical Care a change in status (election or revocation of hospice or death) by a hospice client who is Medicare/Medicaid covered within five (5) working days.

3.2.8 Medicare Crossover

Hospice clients may be dually eligible for Medicare and Medicaid. When a dually eligible client elects Medicare hospice, a copy of the Notice of Election must be sent to DHW Bureau of Medical Care.

Medicare hospice claims will not automatically crossover from Medicare to Medicaid. Claims must be either billed on paper with the Medicare EOB attached, or electronically if your software supports it. Refer to **General Billing, Section 2.5, Crossover Claims**, for more information.

The hospice provider should first bill Medicare for rendered services. Medicaid pays for the coinsurance related to drugs and respite care on the Medicare claim. Medicaid also pays the hospice for the room and board rate at 95% of the daily rate for dually eligible hospice clients residing in a nursing facility.

3.2.9 Type of Bill Codes

Enter the three-digit type of bill code in **Field 4** of the UB-92 or the appropriate field when billing electronically.

137 Outpatient: Replacement of prior claim

138 Outpatient: Void/cancel of prior claim

811 Admit through Discharge

812 Interim, First Claim

For **Medicare Part A crossover claims only,** use the following codes:

813 Continuing Claim

814 Last Claim

3.2.10 Statement Covers Period

The Statement Covers Period field identifies the beginning and ending service dates of the period included on the bill. Late or additional charges outside the scope of the span indicated should be billed on a separate claim form or adjustment request. Medicaid does **not** pay accommodation charges, or any fraction thereof, for the last day of hospice room occupancy when a client is discharged under normal circumstances.

Although there is no reimbursement for the discharge day, enter that date on the claim form. This ensures that the hospice receives reimbursement for the last full day of accommodation. If a client requires extended hospice care and the hospice sends an interim claim, enter client status code 30 in field 22 of the UB-92 or in the appropriate field when billing electronically. This code explains the client is still a client and to reimburse the hospice for the last day on the claim.

Claims for three sequential interim bills would have the following sequential date and client status format:

Claim #	From Date	To Date	Client Status	Days Billed
1	01/15/05	01/31/05	30	17
2	02/01/05	02/15/05	30	15
3	02/16/05	02/24/05	01	8

Enter the dates for Statement Covers Period in **Field 6** of the UB-92 or the appropriate field when billing electronically.

3.2.11 Client Status Codes

Use only the following codes in **Field 22** of the UB-92 claim form or in the appropriate field when billing electronically:

01 Discharged to Home

20 Expired

30 Still a Client, Not Discharged

3.2.12 Occurrence Codes and Dates

Use one of the following codes in **Fields 32-35** on the UB-92 claim form with the date of occurrence or in the appropriate field when billing electronically:

24 Date Insurance Denied

25 Date Benefits Terminated by Primary Carrier

42 Date of Discharge

3.2.13 Hospice Revenue Codes

All hospice services are to be billed using one of the following unique, three-digit revenue codes. Other revenue codes will be denied. Enter the three-digit revenue code in **Field 42** of the UB-92 or the appropriate field when billing electronically.

Service	Rev. Code	Description
Routine Care	651	Daily care provided for general hospice care.
Continuous Care	652	Care rendered during crisis conditions. Requires a minimum of eight hours. Hours are counted from midnight to midnight. This procedure must be billed using units of time in 15-minute increments. Partial blocks may be billed in 15-minute increments. Services must be provided by a registered or licensed practical nurse.
Inpatient Respite Care	655	Respite care is limited to five days per election period (calendar month) for each client in an approved inpatient facility. Respite care may only be rendered in a licensed freestanding hospice or a qualified nursing facility.
General Inpatient Care (Non-respite)	656	Client care must be rendered in an approved inpatient hospital or freestanding hospice bed.
Physician Care	657	Hospice-employed physician services must be billed with the appropriate CPT procedure codes on each line for each service.
Room and Board Care	658	Room and Board reimbursement for a hospice client only occurs when the client has been approved for a level of care in a long-term care facility. Medicaid is always the primary payer of the hospice room and board charge. Per diems are paid for Medicaid or dually eligible hospice clients residing in a Medicare certified nursing facility. The reimbursement rate will be 95% of the nursing facility rate on file in which the hospice client is a resident. Any client liability will be withheld from the total hospice payments.

3.3 Claim Form Billing

3.3.1 Which Claim Form to Use

All claims that do not require attachments may be billed electronically using vendor software or PES software provided by EDS at no cost.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red UB-92 claim forms available from local form suppliers.

All claims must be received within one year of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the *Idaho PES Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.3.2.1 Guidelines for Electronic Claims

Detail lines
Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional claims.

Surgical procedure codes
Idaho Medicaid allows **25** surgical procedure codes on an electronic HIPAA 837 Institutional claim.

Four modifiers

On an electronic HIPAA 837 Institutional claim, where revenue codes require a corresponding HCPCS or CPT code, up to four (4) modifiers are allowed. **On a paper claim**, only two (2) modifiers are accepted.

Revenue codes, which are broken into professional and technical components, require the appropriate modifier. For institutional claims, the TC modifier must be submitted.

Type of bill (TOB) codes
Idaho Medicaid rejects all electronic transactions with TOB codes ending in a value of 6. Electronic HIPAA 837 claims with valid type of bill codes not covered by Idaho Medicaid are rejected before processing.

Condition codes
Idaho Medicaid allows **24** condition codes on an electronic HIPAA 837 Institutional claim.

Value, occurrence, and occurrence span codes
Idaho Medicaid allows **24** value, **24** occurrence, and **24** occurrence span codes on the electronic HIPAA 837 Institutional claim.

Diagnosis codes
Idaho Medicaid allows **27** diagnosis codes on the electronic HIPAA 837 Institutional claim.

National Drug Code (NDC) information with HCPCS and CPT codes
A corresponding NDC is required to be indicated on the claim detail when drug related HCPCS or CPT codes are submitted.

Electronic crossovers
Idaho allows providers to submit electronic crossover claims for Institutional services.

3.3.3 Guidelines for Paper Claim Forms

3.3.3.1 How to Complete the Paper Claim Form

The following will speed claim processing:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly to facilitate electronic scanning.
- Keep claim form clean. Use correction tape to cover errors.
- A maximum of 23 line items per claim can be accepted. If the number of services performed exceeds 23 lines, prepare a new claim form and complete the required data elements. Total each claim separately.
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

See **Section 3.3.3.3**, for instructions on completing specific fields.

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

See **Section 3.3.4.2**, for instructions on completing specific fields.

3.3.3.3 Completing Specific Fields

Refer to **Section 3.3.3.4, Sample Claim Form**, to see a sample UB-92 claim with all fields numbered. Provider questions regarding hospice policy and coverage requirements are referred to the *Rules Governing the Medical Assistance Program,* IDAPA 16.03.09.104.

The following numbered items correspond to the UB-92 claim form. Consult the Use column to determine if information in any particular field is required and refer to the Description column for additional information. Claim processing will be interrupted when required information is not entered into any required field.

Field	Field Name	Use	Description
1	Provider Name and Address and Phone Number	Required	Enter the provider name, address and phone number. The first line on the claim form must be the same as the first line of the RA. If there has been a change of name, address, or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
4	Type of Bill	Required	Enter the three-digit code from **Section 3.2.8** **137-** Outpatient: Replacement of prior claim **138 -** Outpatient: Void/cancel of prior claim **811** – Admit through Discharge **812** – Interim, First Claim **813** – Continuing Claim (Medicare Part A only) **814** – Last Claim (Medicare Part A only)
6	Statement Covers Period	Required	Enter the beginning and ending service dates of the period included on the bill. Medicaid does not pay accommodation charges, or any fraction thereof, for last day of room occupancy when a client is discharged under normal circumstances. However, even though there is no reimbursement for the discharge day, that date should always be entered on the claim form. This ensures that the provider receives reimbursement for the last full day of accommodation. If a client requires extended care and the provider decides to send an interim claim, enter client status code 30 in field 22. This code indicates that the client is still a client and to reimburse the provider for the last day on the claim. See **Section 3.2.10** for information on how to bill claims with sequential interim bills. *NOTE*: If client status 30 is **not** used, the accommodation rate formula will not balance and the system will suspend the claim.
7	Covered Days	Required	Enter the dates for days covered.
12	Client's Name	Required	Enter the client's name exactly as it appears on the MID card. Be sure to enter the last name first, followed by the first name and middle initial. Client name must either be here or in field 58.
17	Admission Date	Required	Enter the month, day, and year the client entered the facility. (This date will be the same on all claims submitted and will not necessarily be the same as the date found in field 6.)
18	Admission Hour	Required	Enter the two-digit hour the client was admitted for care in military time. Example: enter 01 or 02 instead of 1 or 2.
19	Admit Type	Required	Enter a priority admission code from the UB-92 Manual. Only the codes 1, 2, 3, or 4 are acceptable.
20	Admit Source	Required	Enter the two-digit source of admission codes, 01 through 08, from the UB-92 Manual. Example: enter 01 or 02 instead of 1 or 2. Medicaid does not accept 09.
21	Discharge Hour	Required	Enter the two-digit hour the client was discharged from care in military time. Example: enter 01 or 02 instead of 1 or 2.

Field	Field Name	Use	Description
22	Client Status Codes	Required	Enter the appropriate code from Section 3.2.11
32-36	Occurrence Codes and Dates	Required	Use one of the codes listed in Section 3.2.12, Occurrence Codes and Dates, and enter the date of occurrence.
39-41	Value Codes and Amounts	Required	
42	Revenue Codes	Required	All revenue codes are accepted by Idaho Medicaid; however, not all codes are payable. Use revenue code 001 for a total line and enter the claim's total in field 47. See Section 3.2.13.
44	HCPCS/Rates	Required	All accommodation codes require rates.
46	Units of Service	Required	Enter the total number of covered accommodation days, ancillary units of service or visits, where appropriate. Units of service for accommodations must correlate accurately to the service rendered. Example: Accommodation Code = Number of days the service was rendered.
47	Total Charges	Required	Bill total covered charges only. Rate Formula: Total Charges = Rate x Units of Service
50	Payer Identification	Required	If Medicaid is the payer, enter "Idaho Medicaid". If there are other payers in addition to Medicaid, enter the name of the group or plan in fields 50A or 50A and 50B. Enter "Idaho Medicaid" in fields 50B or 50C.
51	Provider Number	Required	Enter the nine-digit Idaho Medicaid provider number in this space.
54	Prior Payments — Payers and Client	Required if applicable	Enter any amount paid by other liable parties or health insurance payments including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
55	Estimated Amount Due	Required if applicable	Estimated Amount Due = Total Charges (field 47) minus Prior Payments (field 54).
58	Insured's Name	Required	Client's name must appear here or in field 12.
60	Cert.-SSN-HIC.-ID NO.	Required	Enter the seven-digit Idaho Medicaid client identification number exactly as it appears on the Idaho Medicaid identification card in this field. If your computer system demands an 11-digit number, zero-fill the eighth through the eleventh digits. Example: 02345670000. All third party resources must be billed before a claim is submitted to Medicaid. If there are other payers in addition to Medicaid, enter the name of the group or plan in field 60A and the Idaho Medicaid number in field 60B; or enter the name of the groups or plans in fields 60A and 60B and the Idaho Medicaid number in 60C. This indicates that Idaho Medicaid is the second or third payer. For Medicare crossover claims, be sure the Medicaid MID number is documented in addition to the Medicare SS number.
67	Principal Diagnosis Code	Required	Enter the ICD-9-CM code for the principal diagnosis.
76	Admitting Diagnosis	Required	Qualis Health, a quality improvement organization (QIO) has designated specific V codes that are not appropriate as admitting diagnoses. Consult the QIO Provider Manual.

Field	Field Name	Use	Description
82	Attending Physician ID	Required	Enter the Idaho Medicaid Provider number or UPIN for the physician referring the client to the provider.
83	Other Physician ID	Required if applicable	Required for Healthy Connections clients referred to the provider by the primary care provider. Enter the primary care provider's Healthy Connections referral number. Desired for all other claims.
85	Provider Representative Signature	Required	Signature of the provider's authorized agent or signature on record. The claim will be denied if it is not signed.
86	Date Bill Submitted	Required	Enter the date the claim is submitted to Idaho Medicaid.

3.3.3.4 Sample Paper Claim Form